BEFORE THE IOWA BOARD OF NURSING HOME ADMINISTRATORS

IN THE MATTER OF:)	CASE NO. 11-003
)	DIA NO. 12NHA001
Steve Drobot)	
)	FINDINGS OF FACT,
Respondent)	CONCLUSIONS OF LAW,
)	DECISION AND ORDER

On February 13, 2012, the Iowa Board of Nursing Home Administrators (Board) issued a Notice of Hearing and Statement of Charges to Steve Drobot (Respondent) charging him with:

Count I: Professional incompetence, in violation of Iowa Code section 147.55(2) and 645 IAC 144.2(3);

Count II: Negligence, in violation of Iowa Code section 147.55(9) and 645 IAC 144.2(12); and

Count III: Violation of a regulation, rule or law of this state, another state, or the United States, which relates to the practice of nursing home administrators, in violation of Iowa Code section 147.55(9) and 645 IAC 144.2(14).

The hearing was held on July 19, 2012 at 9:00 a.m. in the Lucas State Office Building, fifth floor conference room, in Des Moines, Iowa. Respondent Steve Drobot appeared and was represented by attorney Kendall Watkins. The state was represented by Assistant Attorney General September Lau. The following Board members were present for the hearing: Patrice Herrera, RN, MSN, Chairperson; Jeannine Bunge, NHA; David Chensvold, NHA; Maureen Cahill, NHA; Daniel Boor, NHA; Thomas Kenefick, R.Ph.,¹ and Mabel Mantel and Dawnita Neff, public members. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1)(2011), and was recorded by a certified court reporter.

¹ Mr. Kenefick was unable to be present for the Board's deliberations and did not participate in making the decision.

The record was held open until August 8, 2012 for the parties to submit their closing arguments in writing. After hearing the testimony, examining the exhibits, and reviewing the closing arguments, the Board convened in closed session, pursuant to Iowa Code section 21.5(1)(f)(2011), to deliberate its decision. The administrative law judge was instructed to prepare the Board's written decision, in accordance with its deliberations.

THE RECORD

The record includes the Notice of Hearing and Statement of Charges, Continuance Order, and the testimony of the following witnesses: Diane Burkert; FR²'s son; MR's daughter; Amber Hartsch; Erin Folkmann; Tiffany Gourley; John Doughty; Stacy Northrup; Kay Peters; Gwen Suntken; Robert Bender, M.D.; and Respondent. The record also includes State Exhibits 1-14, 16-28, Respondent Exhibits A-L; and the attorneys' briefs.

FINDINGS OF FACT

1. Steve Drobot (hereinafter "Respondent") has been employed as a nursing home administrator in several states since 1993. He was employed by the American Baptist Homes of the Midwest from 1993 through July 2003. On July 17, 2003, the Board issued Respondent Iowa nursing home administrator license number 02223. Respondent was employed by Franciscan Sisters of Chicago Service Corp. from August 2003 until 2008. Respondent reports that he left that employment in 2008 because he did not want to accept a position in the Chicago area. (Testimony of Steve Drobot; Respondent Exhibit G)

Respondent's Employment as Administrator of Windmill Manor

2. On December 1, 2008, Respondent was hired as the Administrator for Windmill Manor (hereinafter "facility") in Coralville, Iowa. At the time of Respondent's initial interview for this position, the Department of Inspections and Appeals (DIA) had just issued a survey report finding more than thirty deficiencies at the facility. As the new Administrator, Respondent became responsible for taking action to correct these deficiencies. (Testimony of Respondent; Exhibit D, p. 13)

² In order to preserve confidentiality of the residents, they are referred to as MR (male resident) and FR (female resident) and their family members are also de-identified in this decision.

- 3. RFMS is the facility's corporate owner. RFMS oversees nursing, dietary, therapy, activities, social services, and maintenance in its facilities. Respondent reported directly to the RFMS Regional Director, Ben Perkins. Mr. Perkins frequently visited the facility after Respondent was hired, but his visits eventually decreased to once every 4-6 weeks. Mr. Perkins and Respondent also spoke on the phone at least once a week. RFMS corporate nurses visited the facility to conduct nursing audits. (Testimony of Respondent)
- 4. When Respondent was hired, Karen Etter had been employed as the facility's Director of Nursing (hereinafter "the DON") for approximately five months. Respondent had daily contact with all of his department heads, including the DON, but he generally entrusted them to operate their departments according to the corporate and legal standards. In the nursing department, Respondent was involved in all hiring above the floor nurse level and in all terminations. Respondent investigated two complaints against the DON and issued two written warnings to her. Neither of these warnings concerned intimidation of staff or retaliation against nursing staff. (Testimony of Respondent; Respondent Ex. F, H)
- 5. The facility has a lot of staff turnover, which is not unusual for medical facilities in the Iowa City area. It is difficult to find qualified staff because there are numerous medical centers and residential facilities within a 25 mile radius of the facility that are competing for the same employees. (Testimony of Respondent; Stacy Northrup)
- 6. The facility has a written Abuse Prohibition Policy. The purpose of the policy is to protect residents from any kind of abuse, including sexual abuse. The following staff is designated as being responsible for implementation of the abuse policy: the Administrator, Director of Nursing, Assistant Administrator, Department Heads/Employees, Shift Coordinators, and Shift Nurses. The abuse policy requires staff to give special attention to identifying behaviors that increase the residents' potential for abusing self or others or for becoming victims of abuse. The policy specifically mentions residents with a history of aggressive behaviors or behaviors such as entering other residents' rooms. Resident care plans are to include appropriate interventions to address identified behaviors. Facility employees who become aware of alleged abuse or neglect of a resident are required to immediately report it to the facility administrator. The policy requires the administrator to notify DIA/DHS of the alleged abuse within 24 hours after the incident becomes known. If another resident was the perpetrator

of the abuse, then the abuse policy required staff to take all necessary steps to protect all residents in the facility from abuse until the alleged perpetrator could be evaluated. All involved parties or potential witnesses were to be interviewed by at least two interviewers, if possible. (State Ex. 9)

The RFMS corporate office had a toll free number to be used by residents, family members, or employees to report any issues at the facility, including abuse. The toll free number was posted at the facility and was included in the employee handbook. (Testimony of Respondent)

7. The DON was verbally abusive towards the facility's nursing staff and repeatedly warned nurses that they would be terminated if they went directly to the Administrator, the corporate office, or the state with any issues in the facility, including abuse. Several nurses have described the DON as a dishonest person who undermined the Administrator and concealed information from him. One nurse testified that after Respondent provided direction to the staff, the DON would pull the nursing managers into her office and tell them "this is how we're actually going to do it." Another nurse testified that the DON had commented that Respondent was on a "need to know" basis. (Testimony of Amber Hartsch; Stacy Northrup; Kay Peters; Erin Folkmann; Tiffany Gourley; Respondent; State Ex. 12, 13)

Respondent testified that he never heard the DON tell staff not to report abuse to him or to the corporate office. At some point, however, he got "wind of" the staff's complaints against the DON and notified the corporate office. According to Respondent, the corporate office sent a nursing consultant to the facility to speak to the nurses and to Respondent. To Respondent's knowledge, the allegations of retaliatory threats by the DON were not substantiated by the corporate office. Respondent was not directed to take any disciplinary or corrective action toward the DON. (Testimony of Respondent; See also State Exhibit 24, p. 197)

In February 2010, DIA investigated allegations of retaliation by the DON, including allegations that Respondent had been present at one nurse appreciation luncheon when the DON made threats. Respondent admitted attending the luncheon but has denied being present for the meeting afterward when the DON reportedly threatened staff. On March 12, 2010, DIA issued its survey report that found retaliation by the facility based on the DON's actions

and fining the facility \$5,000. Respondent suspended the DON the same day he received the report. (Exhibit 13; Exhibit E; Testimony of Respondent)

The DON was later criminally charged with Attempting to Impede Enforcement of Chapter 135C. She was acquitted on August 2, 2010 following a trial. The DON was self-represented at the trial and did not testify. The magistrate found that none of the staff witnesses were absolutely prohibited from contacting the state; they were simply required to follow the chain of command and notify their superior before contacting the state. The magistrate further found that the DON's "flawed style as an administrator and use of intimidation as a tactic to obtain compliance from her staff, though harsh and unprofessional" did not meet the elements of the charged offense. (Exhibit I)

- 8. Several witnesses described Respondent as a caring and hard-working Administrator.
 - Kay Peters, an LPN who served as the facility's Minimum Data Set (MDS) Care Plan Coordinator, had daily contact with Respondent. She described Respondent as friendly, hard-working, and kind; as frequently interacting with residents; and as going above and beyond his normal Administrator duties by helping staff in the dining room and answering resident call lights. Ms. Peters described Respondent as having an open door policy. In her opinion, the DON kept information from Respondent.
 - Erin Folkmann, who was the facility's Social Services and Admissions
 Director, described Respondent as a great Administrator who was very
 approachable by staff. She described Respondent as "very resident
 focused" and always willing to meet with families. She felt that
 Respondent always listened to her concerns, including her concerns about
 the DON, and that he followed up on those concerns.
 - Amber Hartsch, who was the Coordinator of the facility's CCDI (dementia) unit, described Respondent as a good listener who would offer suggestions. In her opinion, Respondent was not proactive. She testified that Respondent visited the CCDI unit every day and spoke to both staff and residents, while the DON rarely visited the CCDI unit. Ms. Hartsch went to Respondent a couple of times with her concerns about the DON but afterward did not see any change in the DON's attitude and demeanor.

FR and MR Admission to the Facility's CCDI Unit; Staff Training Deficiencies

9. In April 2009, FR was admitted to the facility's CCDI (dementia) unit. In addition to dementia, FR had behavioral issues, which included physical aggression, yelling, refusing medications, and pinching and hitting staff. (State Ex. 22, 23; Testimony of Amber Hartsch; FR son)

On November 10, 2009, MR was admitted to the facility. His diagnoses included colon cancer and dementia. Shortly after his admission, MR was moved to the CCDI unit, in part because he believed he was at college and was attempting to leave the facility to go home. MR was flirtatious with the unit's female residents but had no other behavior issues. (State Ex. 19-21; Testimony of Amber Hartsch; MR daughter)

According to the CCDI Unit Coordinator, MR and FR immediately "gravitated towards" each other. FR called MR by her husband's name, and she tended to calm down when MR was next to her. (Testimony of Amber Hartsch; State Ex. 12, p. 66, 70) During his frequent visits to the CCDI unit, Respondent observed MR and FR spending time together, holding hands, and telling stories. (Testimony of Respondent)

10. As the Coordinator of the facility's CCDI unit, LPN Amber Hartsch was responsible for hiring and firing staff on the unit, education and training, social services, preparing MDS, and activities. Pursuant to facility policy, all of the CNAs working in the CCDI unit were required to view an educational video once a year. New staff members were required to view a four hour video for dementia training and to take an exam afterward. There was also on-the-job training specific to the unit. (Testimony of Amber Hartsch; Exhibit 12, p. 69)

CCDI units are subject to special regulations in Iowa, and all staff who work in a CCDI unit must have training appropriate to the needs of the residents. Residents with dementia can be destructive, violent, or sexually aggressive. State regulations require that everyone working in the CCDI unit or facility must be oriented to the needs of people with chronic confusion or dementing illness within 30 days of the assignment. The orientation must be at least six (6) hours in length and shall cover specified topics, which include but are not limited to: communication with CCDI residents and inappropriate and problem behavior and how to deal with it. In addition, licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel

are required to have a minimum of six hours of in-service training annually that relates to the needs of CCDI residents. (Testimony of John Doughty, NHA; State Exhibit 4)

During a DIA investigation conducted in March 2010, Ms. Hartsch admitted that she did not know what state law required with respect to CCDI training although she knew that the corporate office wanted everyone to have 12 hours of training each year. Ms. Hartsch admitted that due to staffing issues there was staff working in the facility's CCDI unit who did not have the required training. The facility terminated Ms. Hartsch's employment on March 20, 2010. (State Ex. 12, pp. 65-69; Testimony of Amber Hartsch)

Based on a DIA survey completed on April 22, 2010, the facility was issued a federal Statement of Deficiencies and Plan of Correction that cited the facility, in part, for insufficient training of its CCDI staff. Although state law required 6 hours of specialized training for dementia unit staff, 11 of the 12 staff working in the facility's CCDI unit only had 4 hours of specialized training. One employee did not receive orientation to the unit until more than 9 months after she was hired. Respondent was no longer employed by the facility when the Statement of Deficiencies was issued. (Testimony of Amber Hartsch, Tiffany Gourley; Respondent; Ex. 17, pp. 168-170)

November 17, 2009 Incident

11. On November 17, 2009 at 3:30 a.m., LPN Starla Wheelock was called to FR's room by two CNAs who had discovered MR and FR in bed together. Ms. Wheelock observed that FR was lying on her back, MR was lying on his side facing FR, and they were talking. When Ms. Wheelock attempted to separate the two residents, she noticed that they were nude from the waist down. FR became very agitated when staff tried to get MR to dress and leave the room. After MR left, Ms. Wheelock attempted to assess FR. FR was combative and resisted any assessment. From what Ms. Wheelock could observe, FR's perineal area did not appear red or swollen. There was no discharge on the bed sheets.

Ms. Wheelock reported her observations to the charge nurse, Angela Hull, who told her not to call the DON at home and that she should wait until morning to speak to her. Based on prior instructions from the DON, Wheelock knew not to document anything of a sensitive nature in the resident chart without first speaking to the DON. Wheelock documented the incident on a separate piece of

paper and left it in the box outside the DON's office. Ms. Wheelock continued to check on FR throughout her shift. At the end of her shift, Ms. Wheelock reported her observations to the oncoming nurse, LPN Stacy Northrup. (Ex. F, pp. 3-4; Exhibit 12, pp. 87-89; Exhibit 24, p. 199)

- 12. Stacy Northrup called the DON immediately, and the DON told Northrup to monitor the residents but not to say anything to anyone or she would lose her job. The DON wanted Ms. Northrup to perform a vaginal examination of FR but Northrop refused because such an examination was not within her scope of practice. She attempted to observe FR for injuries but it was difficult to do so because FR was combative. (Testimony of Stacy Northrup; Exhibit F, p. 4; Exhibit 24, p. 206)
- 13. The DON made late entries to the records of FR and MR at 8:35 and at 8:55 a.m. on November 17, 2009. The DON documented that she called the power of attorneys (POA) for both residents and notified them that the residents had been found in bed, unclothed, and "spooning." FR's son and MR's daughter were the POAs for the residents. (Exhibit 20, p. 178; Exhibit 22, p. 188; Testimony of Diane Burkert)

In MR's record, the DON noted that MR's daughter was very upset that her father would do this, and the DON notes that she explained about dementia and sexual needs and desires. The DON assured MR's daughter that staff would monitor MR and intervene if he tried to do it again and that there was no need to find another placement for him. (Exhibit 20, p. 178)

In FR's record, the DON noted that FR's son was not concerned about the incident and declined the offer of a medical exam. The DON also documented that "Nurse Stacy" had done an exam of the peri and vaginal area and no swelling or tears were noted. (Ex. 22, p. 188)

In the late entries, the DON also documented that she had notified both residents' physician through ARNP Joyce Prater. When the nursing board's investigator contacted Ms. Prater, however, she denied that she was contacted by the facility following the November incident. Ms. Prater recalled being contacted after an incident in December. (Ex. 24, p. 209; Exhibit F, p. 268)

The Board of Nursing later determined that the DON had falsified the late entry in FR's record in regards to the vaginal exam and the report to ARNP Prater.

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The Nursing Board also determined that the DON had violated a number of statutes and rules governing nursing practice. The DON's nursing license was revoked by the Board of Nursing on April 14, 2011. (Respondent Exhibit F)

14. The DON told Respondent about the November 17th incident the following day. Respondent recalled that the DON reported that MR and FR were found in MR's bed, naked from the waist down, talking, and enjoying each other's company. It was Respondent's understanding that there was no evidence of sexual contact between MR and FR. The facility's medical records are entirely computerized. It was Respondent's understanding that the facility's computer was down that evening, which is why the nurse made a separate paper entry about the incident and why the DON made the late entry into the resident's records. (Testimony of Respondent)

Respondent delegated the investigation of the November 17th incident to the DON. The DON's investigation notes indicate that she called ARNP Sherry McKay to report the incident, and that McKay called back after speaking to the residents' physician, Dr. Schilling. ARNP McKay told Respondent that there were no issues so long as the family was aware and have no issues and if the residents both agreed to the action. These notes further indicate that someone spoke to psychiatrist Judith Crosset who advised them that it was a natural act between adults. The DON's notes further indicated that Starla Wheelock was terminated for not documenting the incident and for not calling the DON. The DON's investigation also documented her calls to the family members/POAs of the residents. (Exhibit 25)

After the DON completed her investigation, Respondent reviewed the state regulations pertaining to the reporting of abuse. He determined that the November 17th incident did not have to be reported to the state because there was no caretaker involved and no evidence of force. (Testimony of Respondent)

15. The CCDI unit coordinator, Amber Hartsch, was told that the two residents had been found "spooning" in bed. Changes were made to MR's care plan, starting on November 17, 2009, to implement behavior modifications to decrease his flirtatious episodes, his sexually assertive episodes, and his displays of affection to residents. MR was checked by staff every 15 minutes for about a week following the incident. (Testimony of Amber Hartsch; Exhibit 19, p. 175-176; Exhibit 12, pp. 85, 88, 90)

December 25, 2009 Incident

16. On December 25, 2009 at approximately 8:30 p.m., two CNAs responded to a call light from MR's room and found MR and FR engaged in intercourse. They immediately went to the nurse on duty, LPN Tiffany Gourley, to report their observation. FR was sitting on MR's bed when Gourley entered. MR had an erection and was pulling up his pants. Gourley was new to the unit and had no training on procedures for residents with dementia. Gourley describes FR as confused and combative. Gourley immediately asked another nurse, Amy Sexton, for assistance. FR was biting, kicking, and screaming when the two nurses tried to remove her from MR's room. (Exhibit 26-28; Testimony of Tiffany Gourley)

The nurses called the DON to report what they had seen and also called the nurse practitioner on call to obtain sedating medication for FR. The DON instructed Gourley and Sexton to document the incident on a separate piece of paper, not on the electronic record, and not to tell anyone about the incident. Later the DON told Gourley what to document in FR's record. Gourley documented that the resident was found in a male resident's room with no clothes on below the waist. She also documented that she obtained assistance from Amy Sexton and called the nurse practitioner for a medication order. The DON told Gourley she would handle any report to the state. (Testimony of Tiffany Gourley; Exhibit 27-28; Ex. 22, p. 187; Exhibit 12, p. 81; Exhibit 24, p.198-199; 208)

The DON called Respondent that same night to report the incident. Respondent testified that he was told that staff found FR in MR's room and both of them were naked from the waist down. He was also told that MR had an erection and was found standing behind FR. According to Respondent, the DON told him that there was no clear evidence that intercourse had occurred. Respondent delegated the investigation of this incident to the DON and told her that he wanted to see her notes of staff interviews. Respondent once again checked the state regulations, but determined that the incident was not reportable because there had been no injury and no evidence of force or coercion. Based on his knowledge of FR, Respondent was confident that she would have made it clear to everyone if she was not a willing participant. (Testimony of Respondent)

The DON made an entry into MR's record on (Saturday) December 26, 2009. The DON documented that she called [MR's] daughter and spoke to her at length

concerning her father being in bed with a woman with no clothes on. MR's daughter confirmed that this is all she was told about the incident and that the DON never told her that MR and FR were observed having intercourse. (Exhibit 20, p. 179; Testimony of MR's daughter)

The DON made an entry into FR's record on December 26, 2009 that she called FR's son and let him know that his mom was found in another resident's room and both were unclothed below the waist. She also documented that she told the son that FR was removed from MR's room and became very combative and they had to call [the nurse practitioner] for medication. (Exhibit 22, p. 187) MR's son confirmed that he was called on Christmas Day and informed of the incident. MR's son recalled being told that MR and FR were having sexual intercourse. He confirmed that he may not have wanted his mother to be seen by medical staff because he thought it had been a mutual sexual act. (Testimony of FR son)

FR's son further recalled being called into a meeting with Respondent, the DON, and the Admissions Director, Erin Folkmann, a short time after this incident. He reported being told that staff would speak to his mother's psychiatrist and neurologist but that if they could not change FR's behavior she would be asked to leave the facility. (Testimony of FR's son; Exhibit 12, p. 83)

17. On Monday, December 28, 2009, the DON called ARNP Prater to discuss the December 25th incident. Prater later told the DIA investigator that she was never told that staff witnessed intercourse, and it was her belief that the residents were only found naked in bed. Prater felt it was possible that both residents were seeking out their spouses. ARNP Prater also told the DIA investigator that she spoke to her medical director, Dr. Margo Schilling, and Dr. Schilling consulted a psychiatrist. They all agreed there had been no harm, that patients with dementia can still have the ability to consent, and there was no indication of force. All three thought that the relationship was okay. Prater also told the DIA investigator that the DON wanted her to do a rape examination, but she told the DON that she had to contact the family first. The DON contacted the family and they reportedly did not want the examination. Prater reported that the DON still wanted her to examine FR. On Monday evening, Prater did a brief visual exam of FR and saw no bruising, lacerations, or bleeding. Prater was not willing to subject FR to a pelvic exam. (Exhibit 12, pp. 80-81; See also Exhibit 24, pp. 202-203; 208-209)

- 18. Dr. Robert Bender is a very experienced geriatrician who is the Medical Director of the Healthy Aging and Memory Clinic. In his testimony at hearing, Dr. Bender described the current literature in his field that supports the rights of residents with dementia to engage in sexual activity. In Dr. Bender's opinion, a resident's sexual expression should not be restricted unless it is forceful, in a public setting, or objected to by the residents' family. Dr. Bender reviewed all of the exhibits in this record. Dr. Bender concluded that MR and FR were capable of consenting to sexual activity and that FR was capable of physically and verbally resisting sexual activity if she did not consent. Dr. Bender saw no evidence of any coercion in the two incidents witnessed by the facility's staff. He believed that the facility took appropriate steps by contacting the residents' family members and health care providers, who in turn contacted the residents' physician and a psychiatrist at the University of Iowa. Based on this record, Dr. Bender was persuaded that the sexual activity between FR and MR was consensual. The fact that FR called MR by her husband's name did not change his opinion. (Testimony of Robert Bender, M.D.; Respondent Exhibit L)
- 19. On December 29, 2009, MR's daughter met with Respondent, the DON, and the CCDI unit coordinator to discuss MR's care at the facility. MR's daughter was presented with a contract and told that she would have to sign it if her father was to remain in the facility. The DON had written the contract. The contract was signed that day by Respondent, the DON, the CCDI Unit Coordinator, and MR's daughter. The contract required MR to take his antitestosterone medication daily. It also required MR's family to arrange for a visitor/volunteer to be present every day from 7:00-9:00 p.m., and to provide the facility with a calendar showing the names of the volunteers. If the volunteers/visitors were not present immediate steps for discharge would begin. (Testimony of MR daughter; Respondent; Amber Hartsch; Exhibit 12, p. 68; Exhibit 18)

Due to staffing problems, the facility had previously encouraged other family members to participate in observing residents who required close supervision for various reasons, including a tendency to fall. No one specifically recalled a previous occasion when family members were asked to sign a contract agreeing to provide such supervision. (Testimony of Amber Hartsch; Respondent)

Respondent recalled that MR's family was concerned that MR would have to leave the facility after the December 25th incident. Respondent did not feel that there was any justification to discharge MR at that time, but he did want to

minimize and avoid further sexual contact between FR and MR. It had been the DON's suggestion that the family might be willing to supervise MR during the evening hours. The DON had noted that MR responded to his family better than to staff. It was Respondent's recollection that MR's daughter did not object when asked if the family would provide a volunteer to sit with her father for two hours every evening. Respondent further recalled that it was his supervisor, Ben Perkins, who wanted any agreement with the family put into writing. (Testimony of Respondent; Erin Folkmann)

MR's family agreed to the contract because they liked the facility and wanted to keep him there. They abided by the terms of the contract until late February, when they were told by the CCDI Unit Coordinator that things were going well and they no longer had to provide an evening monitor for MR. There were no further incidents of sexual contact between MR and FR after December 25, 2009. (Testimony of MR daughter; Amber Hartsch)

DIA Surveys; Discharge of MR to Another Facility

- 20. DIA conducted a survey of the facility from February 10-24, 2010 concerning allegations that the DON threatened and retaliated against staff. Respondent's mother had passed away, and he was not present at the facility for the first week of the survey. Respondent was interviewed by the surveyor on February 17, 2010 and stated that he never attended a meeting where the DON threatened to fire staff if they went to corporate or to the state. He admitted that one staff member told him that the DON made this threat, and he spoke to the DON about it. Respondent could not recall what the DON told him but told the surveyor that the staff member took the statement out of context, and he did not see any evidence that staff felt threatened. At the exit interview, the surveyor did not give Respondent any indication what the survey findings would be. DIA did not issue its Fining and Citation #4312 that found retaliation by the DON until March 12, 2010. (Testimony of Respondent; Exhibit 13)
- 21. On March 1, 2010, DIA surveyors returned to the facility to investigate the November 17 and December 25, 2009 incidents and the facility's response to those incidents. The DIA surveyors were present in the facility on the following days: March 1, 3-4, 9, 12, 16-17, 19, 23-25 and April 7 and April 22, 2010. (Exhibit 16)

On Friday, March 12, 2010 at approximately 4:00 p.m., Respondent received a call from DIA employee Kathy Kieler. Ms. Kieler informed Respondent that the facility was in "immediate jeopardy" due to its failure to protect FR from MR. Ms. Kieler told Respondent that the facility would have to immediately abate the situation or face possible decertification. If the facility was decertified, it would not be permitted to care for residents whose care was paid for by Medicare or Medicaid. This would force the facility to close because it would be left with too few residents to continue operations. Ms. Kieler advised Respondent that the facility needed to immediately initiate one-on-one supervision of MR. Respondent and Ms. Kieler also discussed the possibility of discharging MR. (Testimony of Respondent; John Doughty, NHA; State Exhibit 17)

After Ms. Kieler's call, the DON called MR's daughter. Respondent knew that the DON discussed the possibility of discharging MR during this conversation with his daughter but did not know specifically what the DON told her. (Testimony of Respondent) MR's daughter recalled receiving the DON's call at about 4:00 p.m. on March 12, 2010. The DON told MR's daughter that she had to pick her father up right away. MR's daughter told the DON that she couldn't do that and that she was unable to provide the nursing care he required. The DON then suggested that they might be able to get MR admitted to the hospital until they could find a place for him. When MR's daughter asked why MR had to be moved, the DON told her that it was because the state was going to shut the facility down. (Testimony of MR's daughter)

MR's daughter called the DON back about an hour later and then spoke to Respondent. Respondent and MR's daughter do not have the same recollection of their conversation. Respondent recalled telling MR's daughter that they would begin preparations to find staff to monitor her father one-on-one and that on Monday the facility's social services staff would begin assisting her to find an alternative placement for MR. (Testimony of Respondent) It was the recollection of MR's daughter that Respondent told her that the state was going to shut them down, and she would need to find another facility for her father. She further recalled that Respondent told her she would have to come in and monitor MR over the weekend. MR's daughter was unable to do so and did not help monitor her father that weekend. (Testimony of MR's daughter; Respondent)

Late on March 12, 2010, Respondent received a faxed copy of DIA Fining and Citation #4312, which made findings that the DON threatened to retaliate against employees who filed reports with the facility administrator or the state. At 6:23

p.m. on March 12, 2010, Respondent suspended the DON, without pay, pending an investigation by the facility. (Testimony of Respondent; Exhibits 13, I)

The facility's staff provided one-on-one monitoring for MR over the weekend. Respondent went to the facility on Sunday and observed that MR was becoming more agitated and having escalating behaviors because he felt he was being watched. Based on MR's response, Respondent did not think that one-on-one supervision of MR would be successful. (Testimony of Respondent)

22. On Monday, March 15, 2010, the facility's Admissions Director, Erin Folkmann, started discussions with MR's daughter and son concerning MR's discharge. It was Ms. Folkmann's impression that MR's family understood that MR had to be discharged and that the only real issue was where he would go. Both the family and Ms. Folkmann began contacting other facilities. The family contacted an assisted living facility with a dementia unit that was in the Iowa City area, and that facility initially agreed to take MR. Respondent called the facility because he wanted to be certain that the receiving facility understood the reason that MR was being discharged. The assisted living facility later decided it could not accept MR, possibly after consulting with DIA. (Testimony of Respondent; Erin Folkmann; MR's daughter)

Respondent never provided MR or his family with a written notice of involuntary discharge and never told them that they had the right to appeal the discharge to DIA if they did not agree to it. There is no documentation of any counseling, either for MR or his family, in the resident record. Respondent testified that he did not follow the procedures for an involuntary discharge because he considered MR's discharge to be voluntary, not involuntary. (Testimony of Respondent)

MR was eventually accepted by a facility in Maquoketa that had a unit for male residents with behavioral issues. The Admissions Director and Respondent both testified that they were still under the impression that MR's family did not disagree with this transfer and knew it needed to happen. (Testimony of Respondent; Erin Folkmann) MR's daughter testified that she did not want to move her father so far away from Iowa City but felt she had no choice given the short time frame they were given to find a new placement. MR's daughter never refused to move her father, but it was her understanding that she had to move him because the facility was being shut down by the state. MR was discharged

to the Maquoketa facility on or about March 17, 2010. (Testimony of MR's daughter)

- 23. The facility terminated Respondent's employment as Administrator on March 19, 2010. The facility terminated the DON's employment on March 23, 2010. (Exhibit E; Testimony of Respondent)
- 24. On May 5, 2010, DIA issued Fining and Citation #4353, which was based on the survey ending on April 22, 2010. The Fining and Citation found, in part, that: FR had been sexually assaulted by MR on December 25, 2009; that the DON told staff not to discuss the incident with anyone; and that the facility failed to report the incident to DIA. The facility was fined a total of \$45,500. (Exhibit 16)

The facility was also issued a federal Statement of Deficiencies and Plan of Correction following the DIA survey that ended on April 22, 2010. The federal Statement of Deficiencies and Plan of Correction cites many of the same issues that were included in the state Citation and also cites the facility for failure to provide sufficient preparation and orientation for the safe and orderly transfer/discharge of MR. The federal Statement of Deficiencies included the finding of "immediate jeopardy" against the facility. (Exhibit 17; Testimony of John Doughty, NHA)

- 25. DIA investigated allegations of dependent adult abuse against Respondent and considered whether Respondent engaged in willful misconduct, gross negligence, or reckless acts or omissions when acting or failing to act following sexual incidents between MR and FR. On January 7, 2011, DIA concluded that the dependent adult abuse allegations against Respondent were unfounded. (Testimony of Respondent; Exhibit D)
- 26. On January 24, 2011, the facility and DIA entered into a Consent Order to resolve Fining and Citation #4353. Pursuant to the terms of the Consent Order, neither party made any admissions. The parties agreed to:
 - retain all survey findings as written for purposes of licensure history;
 - retain the Citation as: one Class I citation with a \$20,000 fine, held in abeyance; one Class I citation with an associated fine of \$10,000; four Class II citations with associated fines of \$500 each; and one citation for a violation of Iowa Code section 135C.46 (retaliation by facility) with an associated fine of \$2500; and

 retain the Conditional License until such time as DIA issued a Notice of Rescission of the Conditional License and placed the facility back on a full license. (Exhibit 16)

CONCLUSIONS OF LAW

Count I- Professional Incompetence

A. Authority of the Board to Discipline for Professional Incompetence

The Board is authorized to revoke, suspend or otherwise discipline a license to practice as a nursing home administrator for professional incompetence.³ Professional incompetence is defined by Board rule as including, but not limited to:

- A substantial lack of knowledge or inability to discharge professional obligations within the scope of practice;
- A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other nursing home administrators in the state of Iowa acting in the same or similar circumstances;
- A failure to exercise the degree of care which is ordinarily exercised by a nursing home administrator acting in the same or similar circumstances;
- Failure to conform to the minimal standard of acceptable and prevailing practice of a licensed nursing home administrator in this state.4

The state asserts that Respondent is professionally incompetent because he failed to conform to the minimal standard of acceptable and prevailing practice of a nursing home administrator when he:

- 1) failed to report the two incidents between MR and FR to DIA as dependent adult abuse;
- 2) failed to ensure that the facility's CCDI staff had adequate training, as required by 481 IAC 58.54(6);
- 3) entered into an inappropriate contract with MR's family that required the family to provide volunteers to supervise MR for two hours every evening;

³ Iowa Code section 147.55(2)(2009).

^{4 645} IAC 144.2(3).

- 4) failed to exercise the minimum degree of oversight of the DON; and
- 5) involuntarily discharged MR from the facility, without following the procedures required by 481 IAC 58.40.

B. Dependent Adult Abuse Reporting Requirements

A staff member or employee of a nursing facility, who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered dependent adult abuse shall report the suspected dependent adult abuse to DIA.⁵ The definition of "dependent adult abuse" includes physical injury, unreasonable confinement or punishment, commission of a sexual offense, exploitation, or neglect, as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker.⁶ "Caretaker" means a person who is a staff member of a facility or program who provides care, protection, or services to a dependent adult voluntarily, by contract, through employment, or by order of the court.⁷

The state presented the testimony of Diane Burkert, who is a Board of Nursing Investigator, and John Doughty, who is an experienced licensed Nursing Home Administrator. Ms. Burkert and Mr. Doughty both testified that they believed Respondent should have reported the incidents between MR and FR to DIA as possible dependent adult abuse. Mr. Doughty believed that the sexual contact between MR and FR could not have been consensual because both residents had dementia and were vulnerable adults. Ms. Burkert believed that the incidents should have been reported because it was questionable whether the residents could consent. Both Ms. Burkert and Mr. Doughty conceded that MR was not a caretaker. Ms. Burkert believed that the "caretaker" element of the statute may be satisfied in this case, however, because the facility staff was responsible for protecting FR.

Respondent testified that he reviewed the dependent adult abuse regulations as well as his separate obligation, under 481 IAC 50.7, to report any major injury to a resident or any pattern of acts by one resident against another that results in any physical injury. A "pattern" of acts means two or more times within a 30-day

⁵ Iowa Code section 235E.2(2).

⁶ Iowa Code section 235E.1(5)(a).

⁷ Iowa Code section 235E.1(1).

period.⁸ Respondent concluded that there was no duty to report the incidents because there was no evidence of any injury to FR, there was no evidence that any sexual contact between MR and FR was forced, and there was no caretaker involved in the incidents.

Respondent also presented the testimony of Gwen Suntken, R.N., who is an experienced long term care nurse consultant with a master's degree in health care administration. Ms. Suntken agreed with Respondent's assessment that the two incidents were not reportable to DIA as dependent adult abuse because MR was not a caretaker, because there was no evidence of injury, and because the two incidents were more than 30 days apart. Respondent also presented the testimony of geriatrician Dr. Robert Bender, who reviewed the written record and concluded that the sexual contact between MR and FR was mutual and consensual and did not constitute abuse.

The Board reviewed the testimony and exhibits and concluded that the testimony provided by Ms. Suntken and Dr. Bender was more persuasive than the testimony of Ms. Burkert and Mr. Doughty. Based on this record and the information revealed in the facility investigation, it was not unreasonable for Respondent to conclude that the incidents between MR and FR were not reportable to DIA because they were consensual and did not involve a caretaker. Although other nursing home administrators may have taken a more conservative approach and reported the incidents to DIA, the Board was unable to conclude that Respondent was legally required to report the incidents or that the failure to report the incidents constituted professional incompetence.

C. DIA Rules Pertaining to CCDI Unit Training

The Department of Inspections and Appeals (DIA) is responsible for licensing, establishing standards, inspecting, and sanctioning nursing facilities in the state of Iowa. DIA's rules specify that the licensed nursing home administrator is responsible for the overall operation of the nursing facility and for compliance with DIA's laws and rules. DIA's rules further provide that the licensed administrator is responsible for the selection and direction of competent personnel to provide services in the resident care program. 11

^{8 481} IAC 50.7(3).

⁹ See Iowa Code chapter 135C; 481 IAC chapter 58.

¹⁰ 481 IAC 58.9(1)(a), (b).

^{11 481} IAC 58.9(2)(a).

DIA's rules also specify the duties of the health service supervisor (i.e., the Director of Nursing) for each facility.¹² These duties include, but are not limited to, planning and coordinating nursing staff orientation and in-service programs and providing for training of nurse's aides,¹³ ensuring that all nurse's notes are descriptive of care rendered including the resident's response,¹⁴ and keeping the administrator informed of the resident's status.¹⁵

DIA has also adopted rules pertaining to special units or facilities dedicated to the care of persons with chronic confusion or dementing illness (CCDI). ¹⁶ All staff working in a CCDI unit or facility must have training appropriate to the needs of the residents. ¹⁷ This includes at least six hours of staff orientation to the needs of people with chronic confusion or dementing illnesses within 30 days of their assignment to the unit or facility. ¹⁸ In addition, licensed nurses, certified medication aides, social services personnel, housekeeping, and activity personnel shall have a minimum of six hours of in-service training annually, which shall be related to the needs of CCDI residents. ¹⁹

The facility's CCDI staff did not have all of the training required by DIA rule during the time that Respondent was serving as the administrator. The Statement of Deficiencies and Plan of Correction that was issued following DIA's survey in March and April 2010 found that 11 of 12 staff assigned to the facility's CCDI unit were 2 hours short on the required specialized training. In addition, one employee did not receive orientation to the unit until nine months after she was hired.

As the administrator, Respondent was ultimately responsible for ensuring that all employees of the CCDI unit received the required training.²⁰ Nevertheless, it was not inappropriate or unreasonable for Respondent to delegate the CCDI unit training responsibilities to the DON and the CCDI Unit Coordinator. DIA's rules specify that the DON is responsible for planning and conducting nursing staff orientation and in-service programs and for providing training for nurse's

¹² 481 IAC 58.20.

^{13 481} IAC 58.20(7).

^{14 481} IAC 58.20(11).

^{15 481} IAC 58.20(14).

^{16 481} IAC 58.54.

^{17 481} IAC 58.54(6).

^{18 481} IAC 58.54(6(a).

^{19 481} IAC 58.54(6)(b).

²⁰ 481 IAC 58.9(1)(a).

aides.²¹ There is no evidence that Respondent had ever been informed that the CCDI unit staff did not have the required hours of specialized training. The Statement of Deficiencies citing this deficiency was not issued to the facility until after Respondent's employment had been terminated. The existence of this deficiency at the facility does not support a finding of professional competence, particularly when Respondent was not made aware of the deficiency and had no opportunity to correct it.

D. DIA Rules Relating To Involuntary Discharges

DIA has also adopted rules governing the involuntary discharge of residents from nursing facilities.²² A facility shall not involuntarily discharge a resident from a facility except for medical reasons, for the resident's welfare or that of other residents, or for nonpayment.²³ Unless it is an emergency discharge, an involuntary transfer or discharge shall be preceded by a written notice, at least 30 days in advance of the proposed discharge.²⁴ The notice shall include the stated reason for the proposed transfer or discharge, the effective date of the discharge, and a required paragraph explaining the resident's right to appeal the discharge and request a hearing.²⁵ The involuntary discharge or transfer shall be discussed with the resident and the resident's responsible party by the facility administrator or an appropriate designee within 48 hours after the notice of discharge is received. The content of the discussion shall be summarized in writing and made part of the resident's record.²⁶ The resident shall receive counseling services, which shall be documented in the resident's record, to minimize the possible adverse effects of the involuntary transfer.²⁷

The 30-day notice requirement does not apply if an emergency transfer or discharge is mandated to protect the health, safety, or well-being of other residents from the resident being transferred.²⁸ However, the resident must be given a written notice prior to or within 48 hours following emergency transfer or discharge that provides the reason for the discharge and notification of the

²¹ 481 IAC 58.20(7).

²² 481 IAC 58.40.

^{23 481} IAC 58.40(1).

²⁴ 481 IAC 58.40(1)"c."

^{25 481} IAC 58.40(1)"d."

^{26 481} IAC 58.40(1)"1."

^{27 481} IAC 58.40(1)"m."

²⁸ 481 IAC 58.40(1)"c"(1).

right to appeal.²⁹ The 30-day notice requirement also does not apply if the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.³⁰

MR was discharged to another facility on or about March 17, 2010 without any prior written notice of the reason for the discharge, without any notification of his right to an appeal hearing, and without any documentation of counseling, as required by statute for an involuntary discharge. Respondent maintained that the involuntary notice procedures were not required because the family agreed to the discharge.

The preponderance of the evidence does not support Respondent's assertion that the discharge of MR was voluntary. There is no question that Respondent faced a very difficult situation when he received DIA's call informing him that the facility was in "immediate jeopardy," which required immediate abatement. Respondent was told that he either had to provide 1:1 supervision for MR or discharge him. After this phone call from DIA, the DON called MR's daughter and informed her that she had to move her father out of the facility immediately because the state was closing the facility. This information was not accurate. Respondent testified that he did not know exactly what the DON said to MR's daughter, but he knew that the DON's statements were not well received. Respondent spoke to MR's daughter about an hour later and essentially delivered the same message. MR's daughter was led to believe that her father had to be discharged, either because the facility was imminently closing or because "the state" was requiring MR's immediate discharge. It is clear that MR's daughter was not given clear or accurate information concerning DIA's requirements or the issues surrounding her father's continued placement at the facility. MR's daughter did not want to move her father but did not understand that she had any right to resist or appeal the discharge. The preponderance of the evidence in the record supports the conclusion that MR's discharge was involuntary.

As the administrator, Respondent was responsible for ensuring that the facility followed the proper procedures for the involuntary discharge of a resident, and

^{29 481} IAC 58.40(1)"n."

^{30 481} IAC 58.40(1)(c)(2).

he failed to do so in this case. At a minimum, MR and his daughter were entitled to notice of the reason for the discharge and notice of the right to appeal. If the discharge did not qualify as an emergency, they were entitled to a 30 day notice. However, the Board does not believe the failure to follow the involuntary discharge procedure in this case justifies a finding that Respondent is professionally incompetent. Respondent was confronted with multiple difficult compliance issues in a very short period of time. Although he failed to follow proper procedures, the Board believes that this violation should be addressed under Count III as a violation of a regulation of this state rather than as evidence of professional incompetence.

E. Entering Into A Contract with MR's Family To Provide Supervision

The state relied on the testimony of its expert witness, John Doughty, to support its assertion that Respondent departed from the minimal standards of practice when he entered into a contract with MR's family to provide supervision for MR for two hours every evening following the December 25th incident. Mr. Doughty testified that the facility is paid to provide 24 hour care to all of its residents, including whatever supervision the resident requires even if it is 1:1 supervision. In Mr. Doughty's opinion, this responsibility should not have been delegated to the resident's family. Mr. Doughty believed that Respondent departed from minimal standards of acceptable practice when he asked the family to sign the contract.

The Board was not persuaded that the contract violated the minimal standards of practice for a licensed nursing home administrator. Based on the testimony and evidence presented at hearing, it appears that the family voluntarily agreed to provide additional supervision for MR because they wanted him to stay in the facility. Respondent's supervisor at the corporate office wanted the agreement in writing. The DON drafted the contract, and the family agreed to sign it. These circumstances do not support a finding of professional incompetence.

F. Failing to Exercise the Minimal Degree of Oversight of the DON

When Respondent was hired in December 2008, he faced the difficult task of correcting over thirty deficiencies at the facility. Karen Etter had been serving as the facility's DON for more than four months at the time Respondent was hired. Respondent understandably relied upon the DON to manage the nursing staff, to conduct investigations concerning her staff, and to provide and document

appropriate care to the residents. As we now know, the DON was dishonest, was abusive and intimidating to her staff, facilitated and completed inaccurate documentation, and repeatedly concealed information from Respondent. Although Respondent does not have the strongest or most proactive management style as an administrator, the Board was not persuaded that his management of this DON, under the circumstances presented to him, constituted professional incompetence.

In summary, the preponderance of the evidence failed to establish that Respondent is professionally incompetent, as that term is defined by Board rule.

Count II-Negligence

The Board is authorized to revoke, suspend or otherwise discipline a licensed nursing home administrator for committing acts or offenses specified by Board rule. ³¹ Board rule permits the Board to discipline a licensee for negligence in the practice of the profession. Negligence includes the failure to exercise due care, including the improper delegation of duties or supervision of employees or other individuals, whether or not injury results, or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession. ³²

The preponderance of the evidence in the record does not support a finding that Respondent failed to exercise due care or that he improperly delegated duties or supervision of employees or other individuals.

Count III- Violation of a Regulation, Rule or Law of this State

The Board is authorized to discipline a licensee for violating a regulation, rule or law of this state, another state, or the United States, which relates to the practice of nursing home administrators.³³ The preponderance of the evidence established that Respondent violated 481 IAC 58.40 when he involuntarily discharged MR from the facility without providing proper written notice of the reason for the discharge and without providing notification of the right to appeal.

³¹ Iowa Code section 147.55(9)(2009).

^{32 645} IAC 144.2(12).

^{33 645} IAC 144.2(14).

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Steve Drobot is hereby issued a Citation and Warning for his violation of 481 IAC 58.40. Respondent is CITED for this violation and WARNED that further violations could result in more severe disciplinary action. IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6, that Steve Drobot shall pay \$75.00 for fees associated with the disciplinary hearing and \$497.50 for the court reporter fees. The total fees of \$572.50 shall be paid within thirty (30) days of receipt of this decision.

Dated this 11th day of September, 2012.

atres Herres

Patrice Herrera, Chairperson

Iowa Board of Nursing Home Administrators

cc: September Lau, Assistant Attorney General, Iowa Attorney General's Office, 2nd Floor, Hoover Building, Des Moines, Iowa (LOCAL)

Kendall Watkins, Davis, Brown, Koehn, Shors & Roberts, P.C., 215 10th Street, Suite 1300, Des Moines, IA 50309 (CERTIFIED)

Pursuant to Iowa Code section 17A.19(2011) and 645 IAC 11.29, any appeal to the district court from a decision in a contested case shall be taken within 30 days from the issuance of the decision by the board. The appealing party shall pay the full costs for the transcript of the hearing. 645 IAC 11.23.